Guidelines

for the Establishment of Regional Geriatric Programs in Teaching Hospitals

Ministry of Health
Ontario
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FOREWORD

The Ministry of Health has prepared guidelines to ensure a basic understanding of the concept of a regional geriatric program and to share the knowledge gained from the experiences of geriatric programs in Ontario and in other countries, particularly the United Kingdom. These guidelines primarily deal with the hospital based in-patient assessment unit and are intended to:

(1) advise District Health Councils of the Ministry's policies relating to regional geriatric programs and to assist them in the formulation of recommendations;

(2) provide standardization among regional geriatric programs for the purpose of reviewing proposals for approval of funding requests; and

(3) act as an information resource for hospitals.

These guidelines should not be regarded as rigid standards. Their application may vary from region to region to reflect local differences in the needs of the elderly, relationships with existing community and institutional health services, geography, etc.

In developing a comprehensive health care system responsive to the needs of the elderly, the Province will be proposing further initiatives, e.g. a one-stop shopping approach for the provision of community health and social services to the elderly. As initiatives are introduced, these guidelines will be reviewed and revised as necessary.

ACKNOWLEDGEMENTS

The Ministry acknowledges with appreciation the assistance given by geriatricians in Ontario and in the United Kingdom, and health care professionals in providing information and guidance in the preparation of these guidelines.

We wish to thank the staff of the geriatric programs that were visited. Amidst their hectic schedules they took the time to describe their programs, share their experiences and show their facilities.

In addition the Ministry is grateful to the many others who contributed ideas, comments and suggestions to this endeavour.

TABLE OF CONTENTS

Page

FOREWORD.....i

ACKNOWLEDGEMENTS.....ii

I. INTRODUCTION.....1

II. REGIONAL GERIATRIC ASSESSMENT UNIT

Objective.....3
Functions.....3
Target Population.....5
Catchment Area/Referral Population.....5
Referral Patterns.....5

III. PROGRAM PLANNING AND DESCRIPTION

Organization.....7
Program Components And Affiliated Services
- Outreach Multidisciplinary Team.....7
- Out-Patient Clinic.....8
- Day Hospital.....8
- Dedicated General Assessment In-Patient Beds.....8
- Geriatric Psychiatry Beds.....9
- Long Term Care Beds.....9

Relationship to Existing System.....9
Core Services.....9
Adjunct Programs.....10
Follow-up Care.....10
Respite Care.....10

IV. APPROVAL PROCESS

Ministry's Plan.....11
Approval Process.....11

V. PROGRAM MONITORING AND EVALUATION.....13

APPENDIX: PROPOSAL REVIEW CHECKLIST.....15

I. INTRODUCTION

Ontario's elderly currently represent 10% of the total population. By the year 2000, the percentage of elderly population is projected to increase to 14%, with the number of elderly over age 85 more than doubling.

The elderly have a wide range of health needs. Approximately 90% of Ontario's elderly live in the community and the majority live independently without major functional disabilities. Nevertheless, advancing age is generally accompanied by inevitable and frequently irreversible changes in health status. Most elderly have at least one chronic disease which may not pose any restrictions on their abilities to live independently in the community. The majority of those over age 75, however, have multiple problems caused by several chronic diseases and are vulnerable to further illnesses. Consequently, some elderly need assistance to remain in the community and a small group (predominantly the over age 75) require the services only available in institutional settings such as chronic care facilities, nursing homes and homes for the aged.

While the elderly are not typically a sick or disabled group, they challenge our health care system in a number of ways:

- The elderly are major consumers of health care services and require a longer recovery period than the younger population, a higher than average amount of care, and programs oriented towards rehabilitation/restoration;

- some have several diseases concurrently which, in combination, present atypical symptoms. Specialized knowledge of the nature of illness in the elderly is therefore critical for diagnosis, assessment and treatment. However, the majority of Ontario's physicians do not have any formal clinical training in geriatric medicine or geriatric psychiatry;

- the majority of patients who are waiting in acute care beds for placement in long term care settings are elderly.

Ontario's health care system therefore must plan for their growing numbers and specific needs.

To meet these needs, the Province has developed a broad strategic plan for a comprehensive system of health services*. The enhancement of geriatric care in acute and chronic hospitals is a major strategy of the plan and includes as one of its components the establishment of Regional Geriatric Programs (RGPs). In June 1986, the

Minister of Health announced the establishment of one regional geriatric program in each of the following five health science centres:

- Ottawa
- Kingston
- Toronto
- Hamilton
- London

A RGP is a comprehensive, co-ordinated system of health services for the elderly within a region. The program covers a full range of health services:

- a regional hospital based assessment unit
- community health care
- mental health care
- long term care (i.e. chronic, rehabilitation, extended care)
- emergency and acute care

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* The broad strategic plan for the development of a comprehensive system of health services for Ontario's elderly is described in the White Paper, A New Agenda. Copies are available from the Ontario Government Bookstore, 880 Bay Street, Toronto, Ontario M7A 1N8.

II. REGIONAL GERIATRIC ASSESSMENT UNIT

A regional geriatric assessment unit is a hospital based centre of expertise for the diagnosis and care of the elderly. It is staffed by professionals from a variety of health disciplines who have special training in geriatrics. The unit performs multidisciplinary assessments on the frail elderly to make an accurate diagnosis, determine the rehabilitation potential, prepare a treatment plan and initiate appropriate discharge planning. To support these activities, the unit is affiliated with out-patient clinics and day hospitals and has priority access to existing community and institutional health services such as rehabilitation beds, psychogeriatric beds, chronic care beds, extended care beds and community support services. **In establishing these affiliations, the assessment unit acts as the co-ordinating organization for the regional geriatric program.**

Objective

The overall objective is to assist the elderly to live independently in their own communities thereby preventing unnecessary and inappropriate institutionalization.

Functions

A regional geriatric assessment unit has four broad functions:

(1) **Clinical Service** including assessment/diagnosis, evaluation of need for placement and post-discharge follow-up. Rehabilitation may be initiated while the assessment is being completed.

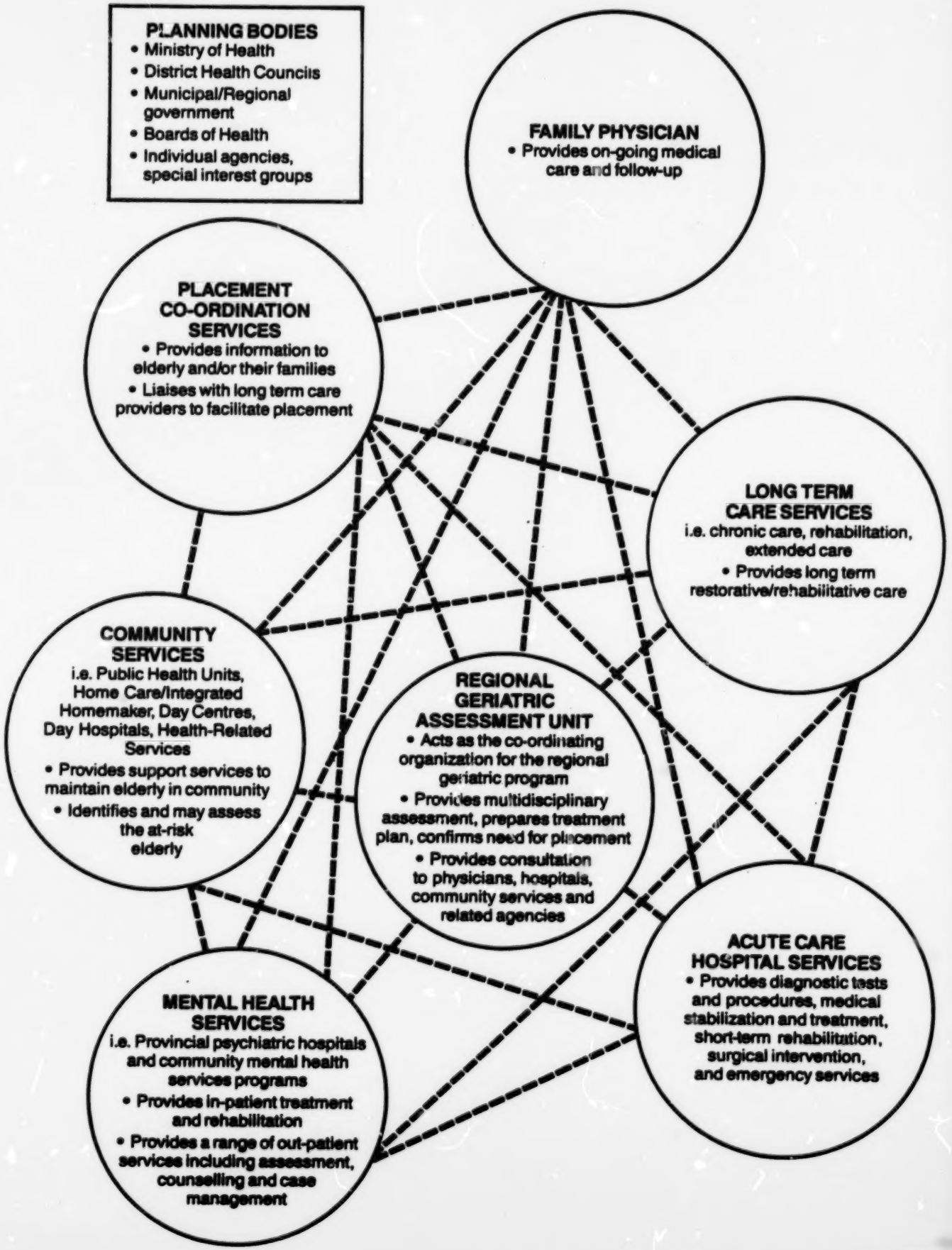
(2) **Teaching/Education** of all health care workers, including health care providers in the community who are involved in the care of the elderly, and volunteers, the elderly and their families.

(3) **Clinical Research** in health care delivery and in the medical problems of old age.

(4) **Consultation** to physicians, hospitals, community health care agencies and to related community health organizations within the region.

The diagram on the following page is intended to show the components of a regional geriatric program, their interrelationships and their relationships to the regional geriatric assessment unit.

COMPONENTS OF A REGIONAL GERIATRIC PROGRAM


PLANNING BODIES
• Ministry of Health
• District Health Councils
• Municipal/Regional government
• Boards of Health
• Individual agencies, special interest groups
FAMILY PHYSICIAN
• Provides on-going medical care and follow-up
PLACEMENT CO-ORDINATION SERVICES
• Provides information to elderly and/or their families
• Liaises with long term care providers to facilitate placement
LONG TERM CARE SERVICES
i.e. chronic care, rehabilitation, extended care
• Provides long term restorative/rehabilitative care
COMMUNITY SERVICES
i.e. Public Health Units, Home Care/Integrated Homemaker, Day Centres, Day Hospitals, Health-Related Services
• Provides support services to maintain elderly in community
• Identifies and may assess the at-risk elderly
REGIONAL GERIATRIC ASSESSMENT UNIT
• Acts as the co-ordinating organization for the regional geriatric program
• Provides multidisciplinary assessment, prepares treatment plan, confirms need for placement
• Provides consultation to physicians, hospitals, community services and related agencies
ACUTE CARE HOSPITAL SERVICES
• Provides diagnostic tests and procedures, medical stabilization and treatment, short-term rehabilitation, surgical intervention, and emergency services
MENTAL HEALTH SERVICES
i.e. Provincial psychiatric hospitals and community mental health services programs
• Provides in-patient treatment and rehabilitation
• Provides a range of out-patient services including assessment, counselling and case management

Target Population

The assessment unit is not required for the general elderly population. As previously mentioned, the majority of elderly do not have complex multiple pathologies accompanying declining functional status and therefore can continue to be well cared for by their family physicians. However, the multidisciplinary assessment unit is intended for the elderly with multiple complex health problems who have the potential for improvement from a rehabilitation program and require specialized multidisciplinary geriatric services. It is estimated that approximately 10-15% of the elderly population can benefit from the services of the unit.

While the size of the target population will vary according to the local situation, similar programs in the United Kingdom have generally used a target population of between 30,000 and 50,000 age 65+ as a planning guideline.

Catchment Area/Referral Population

The catchment area, with the exception of Metropolitan Toronto, coincides with the geographic boundaries of a district health council. However, the unit should accept referrals from outside its region, i.e. from regions/districts which do not have such specialized units.

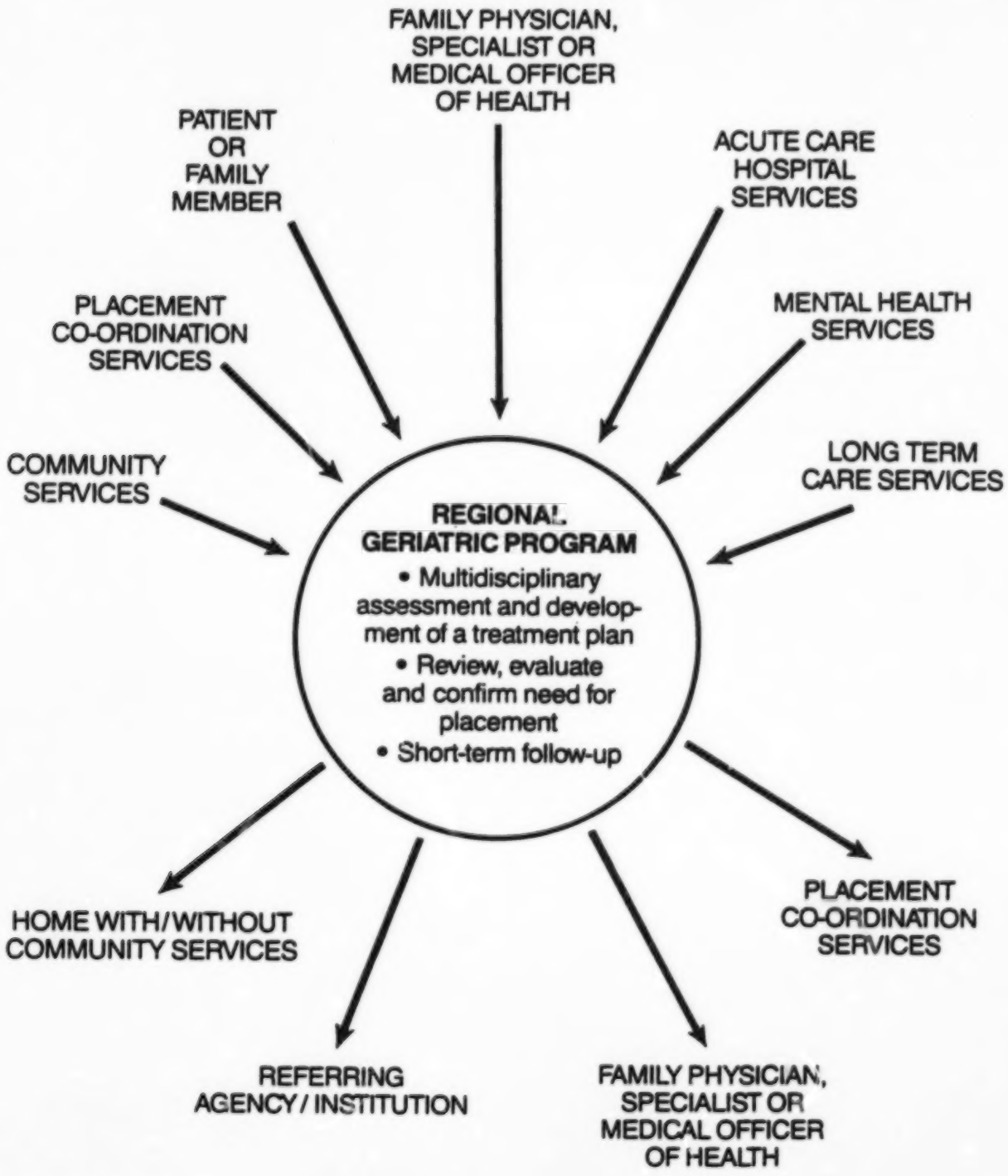
Referral Patterns

As a regional resource, the assessment unit must be equally accessible to all community and institutional health care providers, i.e., no priority will be given to referrals from the "host" hospital. The unit should also accept referrals from all sources, e.g. relatives of the elderly. However, whenever possible, referrals should be made through the family physician. The involvement of the family physician is desirable in order that the unit obtains a medical history and the family physician provides the on-going care of the patient following discharge.

When the patient is ready for discharge, the unit should refer the patient back to the referring physician or agency. Patients requiring institutional placement should be referred to the regional Placement Co-ordination Service. Where such a service does not exist, the unit should arrange placement.

The following diagram illustrates the referral patterns of a regional geriatric assessment unit.

REFERRAL PATTERNS OF A RGP


FAMILY PHYSICIAN, SPECIALIST OR MEDICAL OFFICER OF HEALTH
PATIENT OR FAMILY MEMBER
ACUTE CARE HOSPITAL SERVICES
PLACEMENT CO-ORDINATION SERVICES
MENTAL HEALTH SERVICES
COMMUNITY SERVICES
LONG TERM CARE SERVICES
REGIONAL GERIATRIC PROGRAM
• Multidisciplinary assessment and development of a treatment plan
• Review, evaluate and confirm need for placement
• Short-term follow-up
HOME WITH/WITHOUT COMMUNITY SERVICES
PLACEMENT CO-ORDINATION SERVICES
REFERRING AGENCY / INSTITUTION
FAMILY PHYSICIAN, SPECIALIST OR MEDICAL OFFICER OF HEALTH

III. PROGRAM PLANNING AND DESCRIPTION

The regional geriatric assessment unit is a hospital based program with a centralized in-patient unit, mobile outreach team(s), day hospital(s) and an out-patient clinic. Whether these programs are best located in the same host hospital or at different sites will depend on the local situation. Also, the local situation will determine whether smaller satellite units should be established.

Organization

Sponsorship - Each program component will operate under the auspices of the governing board of its host hospital. It is advisable to establish an appropriate agreement of understanding between the institutions providing one or more services and the in-patient assessment unit to clarify their respective roles and areas of responsibility.

Medical Direction - Each unit shall have a Medical Director. The Medical Director must be a geriatrician, i.e. one who is qualified by the Royal College of Physicians and Surgeons in geriatric medicine and should hold a cross-appointment with the Faculty of Medicine.

Program Components And Affiliated Services

The principal function of the assessment unit is to conduct comprehensive assessments of the frail elderly to determine their medical/functional/psychosocial status. This involves individual evaluations by a geriatrician, clinical nurse specialist in geriatrics, physiotherapist and/or occupational therapist and a social worker. An evaluation by a geriatric psychiatrist may also be made if the patient is confused, depressed or appears mentally ill. Consultations may be done by medical specialists, a pharmacist and/or dietician. Various specialized tests and procedures are also commonly performed. Subsequently, the multidisciplinary team jointly prepares a treatment plan. Short term rehabilitation and discharge planning may be initiated while the patient is undergoing assessment.

The assessment unit requires the following components to support its activities:

. **Outreach Multidisciplinary Team** - The team should comprise a geriatrician, clinical nurse specialist in geriatrics, occupational therapist, physiotherapist and a social worker with special training in geriatrics. A specialist in geriatric psychiatry should be available on a consulting basis. The team

should be responsible for conducting consultations in referring health care facilities and conducting initial pre-admission home assessments. A pre-admission home visit is recommended to determine the level of function which the patient must achieve to restore his/her independence and to identify any associated modifications required to the home to enable the patient to cope in the community. Home visits also allow the team to note the arrangement of bedroom furniture in the patient's home and to recreate this arrangement in the assessment unit if admission is required.

- **Out-Patient Clinic** - The clinic is intended to provide a location where patients can be seen initially to determine whether they are suitable candidates for the program; and where patients can be seen for follow-up after discharge.

- **Day Hospital** - A day hospital is an ambulatory facility which primarily employs health care professionals to provide an organized day program oriented towards diagnostic assessment and regular therapeutic rehabilitation. The day hospital is intended primarily for elderly patients who can be assessed by regularly attending the program for a short period of time as well as those patients who can attend a short term rehabilitation/reactivation program on an out-patient basis. Patients generally attend a day hospital program for about five hours a day, twice a week.

  According to Ministry guidelines, one day hospital place for diagnostic assessment should be planned for every two in-patient assessment beds. In addition, the day hospital may contain one day hospital place for each 1,000 local resident population over the age of 65 for rehabilitation purposes.

- **Dedicated General Assessment In-Patient Beds** - The regional geriatric assessment unit should have dedicated in-patient beds in order to assess patients who cannot attend a day hospital program or who require admission for assessment. These beds should be centralized for the following reasons:

  - the unit can be continually staffed with health care professionals who have the expertise to observe, assess and provide care to the elderly;

  - programs and approaches can be specifically oriented to the patient population. For example, a "no restraint" policy can be adopted since the staff can more easily observe the patient; and

  - the teaching of health care professionals is facilitated.

The preferred location for the in-patient assessment beds is in an acute care general teaching hospital. This setting has on-site specialized diagnostic tests and procedures, specialist consultants and surgical capabilities essential for a comprehensive assessment and stabilization of the patient's medical condition.

- **Geriatric Psychiatry Beds** - The assessment unit requires access to psychiatric beds. It is preferred that these geriatric psychiatry beds be located in the host hospital in order to facilitate liaison between geriatric medicine and geriatric psychiatry. However, as an alternative arrangement, provision can be made in a neighbouring hospital.

- **Long Term Care Beds** - The unit should have priority access to chronic and extended care beds within the region. This arrangement is essential to facilitate the transfer of patients requiring these levels of care and to ensure access to the unit at all times. Hospitals are increasingly choosing to establish specialized geriatric chronic care programs specifically oriented to the needs of the elderly.

Relationship to Existing System

A regional geriatric assessment unit enhances the existing system of health and health-related services for the elderly by providing a centre of multidisciplinary geriatric expertise for assessment and establishing linkages with the existing health services in the region. To achieve this co-ordination, the unit works closely with the community and institutional health providers to receive referrals, exchange information regarding the patient, consult with various paramedical and medical specialists, refer patients for placement, relay patient information for ongoing care to family physicians and advise physicians on the special nature of illness in the elderly. It, therefore, is essential for the regional geriatric assessment unit to establish relationships with family physicians, community agencies, placement co-ordination services and health institutions within the region.

Core Services

The regional geriatric assessment unit requires the services of many health professionals in order to conduct a comprehensive functional, medical and psychosocial assessment. The core services which must be accessible to the unit are:

- Diagnostic Laboratories and Services
- Geriatric Medicine
- Geriatric Psychiatry
- Geriatric Nursing

- Physiotherapy
- Occupational Therapy
- Recreational Therapy
- Social Work
- Dietetics
- Pharmacy

Adjunct Programs

The following services are complementary to the core services and should be made available on an "as required" basis:

- Audiology
- Chiropody
- Orthotics, prosthetic and special device services
- Pastoral care
- Speech language pathology
- Various medical/dental specialties as required

Follow-up Care

The regional geriatric assessment unit should provide follow-up care for at least six months after the patient's initial assessment.

Respite Care

Respite care is an important issue in the delivery of services to the elderly.

The assessment unit should develop referral linkages to a variety of existing facilities to facilitate placement for those in need of such care. These arrangements should include an agreement for priority access of former patients of the assessment unit to the respite care beds.

IV. APPROVAL PROCESS

Ministry's Plan

The Province is committed to the establishment of one regional geriatric program in each of the five health science centres. Two of these programs have been established, i.e., at the Chedoke-McMaster Hospital in Hamilton and at the Ottawa Civic Hospital in Ottawa. The Ministry will request these units to review the guidelines and identify any enhancements necessary to upgrade their programs to full regional status.

In the remaining three health science centres, the Ministry has requested the applicable District Health Councils to collaborate with the Faculty of Medicine and the teaching hospitals in the region and recommend where the regional geriatric assessment unit would be best located.

A formal evaluation of each of the five units will be conducted after they have become fully operational as a regional resource.

Until this evaluation is complete, the Ministry is not in a position to approve proposals received from hospitals or District Health Councils in locations outside of the three health science centres identified above or to approve funding for existing units which are not officially designated as part of a regional geriatric program. However, this does not preclude District Health Councils and hospitals from developing plans for comprehensive regional geriatric services for review/ consultation with Ministry staff.

Approval Process

Proposals from the applicable District Health Councils should conform to the guidelines and should include the following information:

- Recommended location of the regional geriatric assessment unit and the rationale for the selected location;
- A description of the proposed program including a statement of objectives (service, education, and research), identification of all program components and arrangements for their provision;
- Arrangements for the liaison and co-ordination of the assessment unit with other geriatric services in the area;
- A description of the referral patterns;

- Admission and discharge criteria;
- Details of medical direction, physician coverage and university appointment (Faculty of Medicine)
- The defined geographic area it will service;
- Relationship of unit with the university Faculties of Health Sciences (Medicine, Nursing, Dentistry, etc.);
- A capital budget (if required);
- An operating budget which specifies workload assumptions and staffing requirements, and
- A plan for ongoing evaluation and monitoring of the program.

A checklist is provided in the Appendix as a guide to ensuring the proposal is complete and complies with Ministry guidelines.

V. PROGRAM MONITORING AND EVALUATION

An information and data collection system must be established to monitor and evaluate the efficiency and effectiveness of the regional geriatric assessment unit. A statement of program objectives for each of the service, education and research components should be developed. These objectives should be specific and measurable.

The **service objectives** should include setting targets for caseload, percentage of patients returned to the community, percentage of patients discharged to a lower level of care, the patient's status on discharge relative to the treatment goals and lengths of stay. The data collected should include caseload statistics, profile of the number of diagnostic tests provided and health status outcomes. For example,

- number of patients seen, where seen (home, day hospital, clinic, etc.)
- number of admissions, readmissions
- age of patient
- diagnosis
- origin of patient (i.e. community, acute care, chronic care, nursing home, etc.)
- number and source of referrals
- disposition of patient: percentage discharged to chronic care, extended care, community
- type and number of community support services arranged
- length of stay
- type of placement indicated for patient on admission and on discharge
- medical/functional/psychosocial status on admission, on discharge and six months post discharge
- for patients discharged to the community:
  - number of hospital admissions since discharge
  - number of patients requiring institutional placement following discharge
  - length of time patient was able to be maintained in community

The use of resources to meet the program's objectives should be clearly stated in the annual budget preparation. Details of the professional skills required, the numbers of staff in each area and their projected productivity are necessary in determining resource requirements.

Patient characteristics, staffing and budgetary requirements should be planned annually, recorded monthly and monitored quarterly. Annual comparisons of the program should be made to identify trends and monitor activity.

A record of the type and number of services provided should be maintained. Additionally the individual patient's file should include a record of all services provided to facilitate chart audits by the program director.

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APPENDIX

PROPOSAL REVIEW CHECKLIST

1. The recommended site is a hospital affiliated with a health science centre.

2. There are appropriate co-ordination mechanisms established with all local providers of elderly services.

3. There is a statement of objectives which includes:

   - clinical services
   - teaching/education
   - research
   - consultation

4. Details of the scope of the clinical services include:

   - assessment/diagnosis
   - discharge planning
   - short term follow-up (i.e. 6 months post discharge)

5. There are details of the medical direction, medical staff organization and coverage including the availability of a geriatric psychiatrist and various medical/dental specialties as required.

6. The Medical Director is qualified by the Royal College of Physicians and Surgeons in geriatric medicine.

7. There is a description of the relationship of the regional geriatric assessment unit to the university Faculties of Medicine.

8. The assessment unit will accept referrals from any source.

9. The regional geriatric assessment program consists of:

   - dedicated, centralized, general assessment in-patient beds
   - a mobile outreach team. The team will consist of:
     . a geriatrician
     . a clinical nurse specialist in geriatrics
     . a physiotherapist
     . an occupational therapist
     . a social worker
     . a geriatric psychiatrist (on a consultation basis)

- a day hospital. The number of day hospital places for **rehabilitation** conforms to the Ministry's guidelines. The number of day hospital places for **assessment** conforms to the Ministry's guidelines

- an out-patient clinic

10. If the components of the assessment unit are located in more than one facility, there are written agreements between these facilities and the Medical Director clarifying their respective roles and areas of responsibilities.

11. There is a written agreement between the unit and applicable institutions for priority access to:

    - psychiatric in-patient beds
    - chronic/rehabilitation beds
    - nursing home beds

12. There are provisions for the following core services:

    - Diagnostic Laboratories and Services
    - Geriatric Nursing
    - Physiotherapy
    - Occupational Therapy
    - Recreational Therapy
    - Social Work
    - Dietetics
    - Pharmacy

13. There are provisions for the following complementary services:

    - Audiology
    - Chiropody
    - Orthotics, prosthetic and special device services
    - Pastoral care
    - Speech language pathology

14. There are provisions for diagnostic tests and procedures. There are arrangements for the transportation and escort of the patient, if applicable.

15. There is provision for respite care in a variety of settings. There is an agreement between the assessment unit and each of the sponsoring settings.

16. A preliminary operating budget has been prepared.

17. A preliminary capital budget has been prepared.

15. There is provision for respite care in a variety of settings. There is an agreement between the assessment unit and each of the sponsoring settings.

16. A preliminary operating budget has been prepared.

17. A preliminary capital budget has been prepared.